CHRISTOPHER WAYNE LESTER

1 OF 14

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM:
Thomas Memorial Hospital
(Medical Records Department)
4605 MacCorkle Avenue SW
South Charleston, WV 25309
(304) 766-3740

DELIVER TO:
Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

THE ENCLOSED DOCUMENT CAN BE IDENTIFIED BY NUMBER 500688044-0001.

Case No. **C-1-01-428**

Michael W. Harris	: **Southern District Court**
	:
vs.	: **County of Hamilton**
	:
Purdue Pharma L.P., et al	: **State of Ohio**

Records pertaining to: **Christopher Lester**

Custodian of Records For: **Thomas Memorial Hospital (Medical Records Department)**

I have conducted a thorough search of our files for the requested records, including but not limited to: patient intake forms and health questionnaires, and/or consent forms, and/or physical examination records, and/or x-rays, and/or pathology slides and/or blocks, and/or all nurses notes and physicians notes, and/or treatment records and reports, and/or prescription records, and/or third-party consultation records, and/or records of treatment at hospitals and other health care providers, and/or test results from outside laboratories, and/or itemized billing records, and/or insurance claims forms, and or personnel records and/or payroll records, and/or academic records, and/or correspondence.

I certify that nothing has been removed from the original file before releasing copies of these records or the originals. The records I am releasing are the original records or exact duplicates of the original records and include each and every record contained in the file on the above-named individual.

Shanna M. Burkhart, RHIA
AFFIANT

Shirley Smith
WITNESS

8-11-03
DATE

I:\MLSDOCS\Oxycontin\Lester\CERT.DOC

1/31/01 10:51am
FAXED

Metro MRI
Thomas Memorial Hospital
Working To Serve Our Community

PATIENT NAME: LESTER, CHRISTOPHER W
MRN: TMP2001013000180
ORDERING PHYSICIAN: JOHN MARK SNYDER, DO

DOB: [redacted]/1971 AGE: 29Y
DATE OF EXAM: 1/30/2001
ROOM: -
SERVICE: OPT

MRI

DATE OF EXAMINATION: 1/30/2001

INDICATIONS FOR PROCEDURE: NUMBNESS LEFT ARM AND HAND, LEFT SHOULDER PAIN. LIMITED RANGE OF MOTION.

MAGNETIC RESONANCE IMAGING LEFT SHOULDER:
No fracture or dislocation is identified. No evidence of impingement. Visualized portions of the rotator cuff appear intact. No other significant findings noted.

IMPRESSION: NO DEFINITE ACUTE PATHOLOGY. NO CONCLUSIVE EVIDENCE OF A ROTATOR CUFF TEAR.

This document was electronically signed by David Abramowitz, M.D. on 01/31/2001 09:39:47.

DA/gz
Dictated: 01/30/2001 16:30:38
Transcribed: 01/30/2001 19:40:03
Voice Job ID: 283228
Document #: 196280
cc:

ASHTON PLACE SHOPPING CENTER
1095 PLEDDERJOHN ROAD • CHARLESTON, WEST VIRGINIA 25314
(304) 345-4MRI • (304) 343-0749 FAX

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM:
Saghir-Ur Rehman Mir, M.D.
401 6th Avenue, P.O. Box 839
Montgomery, WV 25136
(304) 442-5176

DELIVER TO:
Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

USA 2003-0008677

THE ENCLOSED DOCUMENT CAN BE IDENTIFIED BY NUMBER 500688086-0052.

dcn 46341
3/10/2—

CHRISTOPHER W. LESTER SR DOB: 12-23-73 SS# 233-15-3340 CLAIM# 200046841

Figure 75. Lumbar Range of Motion (ROM)*

Name Christopher Lester Soc. Sec. No. [redacted]3340 Date 8/6/00

Movement	Description	Range						
Lumbar flexion	T12 ROM	50	50	53				
	Sacral ROM	25	30	30				
	True lumbar flexion angle	25	20	2—				
	≤10% or 5°?	Yes —	No					
	Maximum true lumbar flexion angle	25						T 46 3E
	% impairment							
Lumbar extension	T12 ROM	12	12	10				
	Sacral ROM	2	2	-1				
	True lumbar extension angle	10	10	9				
	≤10% or 5°?	Yes —	No					
	Maximum true lumbar extension angle	10		(Add sacral flexion and extension ROM and compare to tightest straight-leg-raising angle)				
	% impairment							
Straight leg raising (SLR), right	Right SLR	30	30	30				
	≤10% or 5°?	Yes —	No	(If tightest SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid)				
	Maximum SLR right	30						
Straight leg raising, left	Left SLR	50	40	40				
	≤10% or 5°?	Yes —	No	(If tightest SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid)				
	Maximum SLR left	40						
Lumbar right lateral flexion	T12 ROM	17	18	18				
	Sacral ROM	2	3	3				
	Lumbar right lateral flexion angle	15	15	15				
	≤10% or 5°?	Yes —	No					
	Maximum lumbar right lateral flexion angle	15						T 66 Z2
	% impairment							
Lumbar left lateral flexion	T12 ROM	17	17	17				
	Sacral ROM	2	2	2				
	Lumbar left lateral flexion angle	15	15	15				
	≤10% or 5°?	Yes —	No					
	Maximum lumbar left lateral flexion angle	15						
	% impairment							
Lumbar ankylosis in lateral flexion	Position			(Includes any impairment for abnormal flexion or extension motion)				
	% impairment							

Total lumbar range of motion and ankylosis* impairment ______ %. NOT MMI

*If ankylosis is present, combine the ankylosis impairment with the range-of-motion impairment (Combined Values Chart, p. 322). If ankyloses in several planes are present, combine the ankylosis estimates (Combined Values Chart), then combine the result with the range of motion impairment.

[signature]

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM: Montgomery General Hospital
(Pathology Department)
401 6th Avenue, Box 270
Montgomery, WV 25136
(304) 442-5151

DELIVER TO: Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

THE ENCLOSED DOCUMENTS CAN BE IDENTIFIED BY NUMBERS 500688099-0001 THROUGH 500688099-0002.

RUN DATE: 08/11/03 Montgomery Medical Records PAGE 1
RUN TIME: 1314 CORRESPONDENCE REQUEST DETAIL
RUN USER: MRI.CL

REQUEST # 5673 **STATUS:** LOGGED **TYPE:** OTH

DATE NEEDED:
REQUESTOR: **LOGGED ON:** 08/11/03
NAME: THE MARKER-HOFF GROUP, INC **LAST LETTER:**
ADDRESS: 13105 NORTHWEST FREEWAY **COMPLETED BY:**
SUITE 300
HOUSTON, TX 77040
PHONE:

UNIT #

PAID? **PAGES:** **FEE:**

COMMENTS
A THOROUGH SEARCH OF OUR FILES INDICATE
THAT THERE IS NO RECORD FOUND FOR:
CHRISTOPHER WAYNE LESTER.

ACTIVITY	DATE	TYPE	USER	LETTER
	08/11/03	STATUS LOGGED	MRI.CL	

Montgomery General HOSPITAL
401 Sixth Avenue • P.O. Box 270 • Montgomery, WV 25136-0270 • (304) 442-5151

RE: James Christopher Wiley, Jr. Date: 5/11/03

Dear: Marker-Hoff Group

We are unable to comply with your request concerning the above named patient, as indicated below by check mark (✓).

Please complete and return to us at your earliest convenience.

_____ The information you requested is enclosed.

_____ Hospital policy requires written authorization by the patient before medical information is released. If the patient is a minor, or unable to sign, the enclosed authorization must be signed by the patient, next of kin, or legal guardian.

__✓__ A thorough search of our files has failed to reveal a record on the above named patient. If you can provide additional information, please contact us.

_____ The above named patient is currently hospitalized. The information requested will be forwarded following discharge of the patient.

_____ Additional data is required to facilitate answering your request. Please forward the following information.

Name at the time of admission ______________________

Address at the time of discharge ______________________

Date of birth ______________________

Any other name patient may have been under ______________________

Date(s) of treatment: Inpatient __________ Outpatient __________

Other: ______________________

Respectfully yours,
[signature]
Medical Records

500688.099.0002

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM:
Nolan C. Parsons, Jr., M.D.
331 Laidley Street, Suite 403
Charleston, WV 25301
(304) 344-2721

DELIVER TO:
Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

THE ENCLOSED DOCUMENT CAN BE IDENTIFIED BY NUMBER 500688133-0001.

Cause No. C-1-01-428

Michael W. Harris	: Southern District Court
vs.	: County of Hamilton
Purdue Pharma, L.P., et. al.	: State of Ohio

AFFIDAVIT OF NO RECORDS

Records Pertaining To: **Christopher Wayne Lester**

Type of Records: **Nolan C. Parsons Jr., M.D. (Medical & Billing Records)**

(Custodian of Records)

I, the undersigned, am the duly authorized Custodian of Records for **Nolan C. Parsons Jr., M.D.**, am over eighteen (18) years of age, competent of making this affidavit and personally acquainted with the facts herein stated:

(a) That a thorough search of our files, carried out under my direction and control, revealed no records on the person(s) named in the attached authorization.

(b) It is to be understood that this does not mean that records do not exist under another spelling, another name or under another classification, but that with the information furnished our office and to the best of our knowledge, no such records exist in our files.

_____

AFFIANT (Custodian of Records)

Custodian of Records for: _____

Sworn to and subscribed before me on this the _____ day of _____. 20___.

_____

NOTARY PUBLIC

My Commission Expires:_____

Retention Policy: (The number of years records are maintained prior to destruction) _____

Comments: (Reason why records are not available) have no Records on file

Order No. 500688-133

Diana Willard - receptionist
3/19/03

NOREC/

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM:
Saghir-Ur Rehman Mir, M.D.
401 6th Avenue, P.O. Box 839
Montgomery, WV 25136
(304) 442-5176

DELIVER TO:
Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

THE ENCLOSED DOCUMENTS CAN BE IDENTIFIED BY NUMBERS 500688086-0001 THROUGH 500688086-0051.

SAGHIR R. MIR, M.D., F.A.A.O.S.
ORTHOPAEDIC SURGERY
MONTGOMERY GENERAL HOSPITAL
MONTGOMERY, WEST VIRGINIA 25136

TELEPHONE (304) 442-5176
(304) 442-5151 EXT. 100

June 26, 2001

Workers' Compensation Fund
PO Box 431
Charleston, WV 25322-0431

RE: LESTER, CHRISTOPHER W., SR.
DOB: [redacted]71
SS#: [redacted]340
DOI: 03/10/2000
CLAIM#: 2000046841
EMPLOYER: D & M Trucking Corp., Inc.

Dear Sir/Madam:

This patient was evaluated by me on 06/25/01 at your request. His extensive records were reviewed. Some of his records from previous injuries for reference were reviewed. Detailed history was obtained, and a physical examination was carried out.

REVIEW OF RECORDS AND HISTORY: This patient sustained multiple injuries on 03/10/00 when he fell backwards when a hood of a truck knocked him down while checking his oil; he fell four to five feet. He hit another truck, hit his head and then landed on his left side injuring his rib cage and left shoulder. This patient stated he was knocked unconscious. He was dazed for 40 minutes. He was seen at Charleston Area Medical Center (CAMC) on the same day in the emergency room by Dr. David Bailey. He noted this patient had multiple injuries. He had complaints of pain in his neck, lumbar spine, left shoulder, left hip, pelvis and had several x-rays of those areas which were reported normal. I do not believe he had x-rays of his left knee or rib cage. For further follow up he was sent to Corporate Health. There were close to 37 pages of hospital records in his file. There were several x-ray reports which reported no fractures.

After this patient was discharged from the hospital he started follow up at Corporate Health. He was seen there by several doctors. Dr. Kwei and Dr. Marsha Bailey mainly saw him. He saw a couple of other residents. At the time of his follow up Dr. Kwei had consulted Dr. Sherry Apple on the phone. He saw Dr. Marsha Bailey on 03/14/00 and was noted to have multiple injuries after he fell six feet away from a truck. He was still having some nausea. He also complained of some drainage from his left ear. Mostly he

REVIEW OF RECORDS AND HISTORY: Continued
had pain in his neck and left shoulder area. Neurologically he was essentially within normal limits. His physician called Dr. Apple regarding drainage from his ear and she recommended him to be seen by Dr. Phillips, an ENT specialist, to make sure he had no fractures of temporal bone. He was diagnosed having cerebral concussion. He was treated conservatively with medications.

On 03/15/00 he had already seen Dr. Phillips who had done audiogram. There was some hearing loss bilaterally which was not injury related. There was no evidence of fractures. He did not find any direct injury to ear or internal ear. There was no drainage noted.

He continued periodic follow up with Dr. Bailey. He complained of headaches and some chest pain. For his shoulder pain he had a MRI done. He was continued on medications and local heat. He saw Dr. Bailey on 03/22/00 and was continuing to have headaches, neck pain and left shoulder pain. It was interesting to note in the beginning most of his symptoms were concentrated around his neck and shoulder areas. Later on he complained of some symptoms in his lower back. On 03/21/00 he had a MRI of left shoulder which was reported negative. After his MRI he was started on physical therapy. He was managed with Flexeril, Ibuprofen and Darvocet-N.

He was seen by Dr. Bailey on 03/27/00. She noted his MRI of left shoulder to be normal. He still had tenderness in his neck and left scapular muscles with restriction of mobility. His neurological examination was normal. Physical therapy was started, which he received at Boone Memorial Hospital starting as of 04/03/00. He had some records of physical therapy from Boone Memorial Hospital.

During that time this patient requested to be transferred under the care of Dr. Snyder and such transfer was allowed by compensation. On 06/19/00 his physician noted physical therapy was not helping him and was causing increased symptoms so his physical therapy was stopped. As he was having significant symptoms in his left shoulder an orthopaedic consultation with Dr. Loimil was requested. Over the next few months he continued follow up with Dr. Snyder in the Madison area.

It was noted before he had been treated by Dr. Snyder for an injury to lower dorsal area with a possibility of a fracture of T11-T12 area He received 10% impairment from that injury and missed three years from work.

The first time he saw Dr. Snyder was on 04/07/00. He was noted to mostly have pain in his neck, left scapula area and shoulder. He had stiffness in his neck and shoulder; Motrin, Flexeril and Vicodin were prescribed.

REVIEW OF RECORDS AND HISTORY: Continued
On 04/10/00 compensation allowed his claim to be head injury, thoracic strain, lumbar strain and cervical strain. He saw Dr. Snyder on 04/26/00 and was still having symptoms at multiple areas. He complained of some symptoms in his left knee though there was no mention of left knee injury initially. There was still tenderness in his left rib cage area. Vicodin was recommended and compensation authorized that on 05/05/00. His physician requested additional physical therapy which was allowed by compensation on 06/06/00.

He was released for light duty work. On 04/18/00 his employer wrote a letter to compensation stating they did not have any light duty work. He continued to stay on compensation benefits. He was referred to rehab services on 04/02/00. He had an initial vocational evaluation through Vass Rehab Services on 05/05/00. He continued periodic follow up with Vass Rehab Services at monthly intervals over the next several months.

Over the next couple of months he continued to see Dr. Snyder. He saw him on 07/10/00 and was still having significant pain in his left shoulder area. Now, he was complaining of pain in his lower back along with headaches and neck pain. He had restriction of mobility at his spine and left shoulder though neurologically he was intact. On 07/17/00 and 07/31/00 he was seen by his physician and more or less he had the same symptoms. A consultation with Dr. Loimil was recommended.

I saw this patient at the request of WV Workers' Compensation on 08/02/00. At that time he was continuing to have symptoms so I recommended further treatment. I recommended MRIs on his neck and lower back as well as x-rays of his left shoulder. Also, EMG studies were recommended. I recommended him to be seen by Dr. Loimil regarding his left shoulder.

He continued to see Dr. Snyder. After compensation granted authorization he had cervical and lumbar MRIs which were done on 09/12/00 and was negative for any disc herniation. He had x-rays of his left shoulder and AC joint done on 08/30/00, which were reported normal. His x-rays of rib cage were also negative. On 10/02/00 he had NCS done by Dr. Pratt on his upper extremity, which were also negative.

He had a neurosurgical consultation with Dr. Amores on 10/06/00. He had neck pain with pain going into left arm. He had some limitation of Range of Motion (ROM) at his neck. Neurologically he was intact. Dr. Amores noted his MRI of cervical and lumbar spine to be negative. It was felt he had musculoskeletal strain involving his neck and lower back without neurological deficit. He should continue on conservative treatment.

He had an orthopaedic consultation done by Dr. Loimil on 08/17/00. He was noted to have restriction of mobility and pain in his left shoulder. Dr. Loimil noted he had a MRI

REVIEW OF RECORDS AND HISTORY: Continued
of his left shoulder on 03/21/00. He recommended another MRI on his left shoulder. He indicated he will accept this patient for treatment. For some reason he never went back or saw Dr. Loimil again.

From his records it appears he may have had some additional physical therapy during August and September 2000. I reviewed several records of physical therapy. He continued to see Dr. Snyder at three to four weeks interval. Last time he brought his office notes when I evaluated him in August 2000 and those were reviewed by me. He had seen Dr. Snyder on 08/07/00, 09/26/00, 10/11/00 and 11/19/00. More or less his diagnoses and treatment was the same. He saw Dr. Snyder on 11/22/00 and still had neck and low back pain. He was waiting for the results of Dr. Loimil's consultation. Also Dr. Snyder, on 11/27/00, requested a pain clinic evaluation and management. Dr. Snyder also recommended a psychiatric consultation and follow up with Dr. Settle. His records indicate around about Thanksgiving he was hospitalized with some pain in his dorsal spine when he hit his back against some steps when his legs gave out.

On 12/12/00 he saw his physician again. He was already started on Oxycontin along with DepoMedrol. Prior to that, mostly, he was managed with Vicodin, Flexeril and Vioxx.

I reviewed several reports from Vass Rehab Services. After his initial report he had reports dated 06/28/00, 09/27/00, 12/06/00 and 01/18/01. At that time they closed his rehab claim until he improved. There were several other letters of extension of temporary benefits. On 04/03/01 compensation allowed an orthopaedic consultation. They also allowed his medications as well as additional physical therapy during that time.

On 12/22/00 he had an IME done by me at the request of WV Workers' Compensation. At that time he was continuing to stay symptomatic. I recommended additional follow up with Dr. Loimil. I also recommended a pain clinic consultation and follow up.

On 01/08/01 compensation closed his rehab. On 01/19/01 he was allowed a pain clinic consultation. On 01/10/01 they allowed him to have follow up with Dr. Loimil after his shoulder MRI. On 11/29/00 he was allowed a second MRI on his shoulder at the request of his physician dated 10/17/00.

On 02/27/01 his physician noted him still having pain in his neck and lower back. He was complaining of some weakness in his right leg. He had some numbness and tingling on the medial side of left upper extremity. His shoulder was still having restriction of mobility. Neurologically he was intact. Dr. Snyder indicated he was suppose to see Dr. Saldanha at the pain clinic and he was also going to see Dr. Loimil.

REVIEW OF RECORDS AND HISTORY: Continued
On 02/28/01 he saw Dr. Saldanha at the Pain Clinic. He was noted to have generalized neck and low back pain. Neurologically he was intact Dr. Saldanha diagnosed him having lumbar arthropathy and cervical strain. He recommended facet joint injections for his lower back and trigger point injections for his neck area. As far as his left shoulder was concerned he recommended an orthopaedic follow up with Dr. Loimil. On 03/28/01 compensation allowed facet joint and trigger point injections.

On 03/02/01 compensation allowed a psychiatric consultation. This patient stated he could not see Dr. Settle so he was scheduled to see Dr. Riaz. Now, for three months or so he has been seeing him once a month. He has changed his medications which were being prescribed for his nerves by Dr. Snyder. He is also seeing a psychologist every two weeks.

On 03/28/01 he saw his physician again. It was noted previously he was referred to see Dr. Loimil but for some reason his physician requested his orthopaedic consultation be changed to Dr. Surface.

On 01/30/01 he had a repeat MRI of his left shoulder which reported no evidence of tear in the rotator cuff or any other acute pathology. Again, previously he had MRIs of his cervical and lumbar spine which were negative. His x-rays of AC joint with and without weights were also negative.

At present he is not seeing Dr. Loimil and has not seen Dr. Surface.

Today this patient told me he has been having injections at the Pain Clinic. The first set of facet joint injections was about one and half months ago. Then, he was seen by Dr. Saldanha and had trigger point injections. Last week he had another set of facet joint injections. Next week he is going to see Dr. Saldanha who is going to give him further trigger point injections. Those injections only helped him for a few days.

Besides going to the Pain Clinic and seeing Dr. Riaz he is seeing Dr. Snyder at three to four month intervals who is prescribing his pain medications. At home he uses heat or ice. His wife massages his neck and back.

There were several letters of correspondence in his file from WV Workers' Compensation. There were several letters of authorization for medications. There were some records regarding patient applying for Disability Social Security, which has been denied two times; he is still applying for it.

REVIEW OF RECORDS AND HISTORY: Continued
Today this patient specifically told me that his previous injury which he received 10% was from his dorsal spine area and not from his lower back.

PRESENT COMPLAINTS AND FUNCTIONAL LIMITATIONS: He continues to have pain at cervicodorsal and left scapular areas all the time; it is an aching and burning type of pain. Intermittently the pain goes into his left arm. He has some numbness and tingling in left little and ring fingers. His neck stays stiff. He has generalized weakness in left upper extremity.

His left shoulder aches and hurts most of the time; it wakes him up at night time. He has restriction of mobility at left shoulder.

He has mild soreness in left rib cage area but no shortness of breath.

His lower back aches and hurts all the time. The pain from his lower back goes into both legs. He has numbness and tingling in his legs. Prolong sitting, standing, walking or riding in a car increases his back symptoms. Lying down does not help him. He stated since he started going to the Pain Clinic he has noted occasional dribbling. He is able to manage activities of daily living by himself.

He stated both of his knees give out. At the time of injury he complained of some symptoms in his left knee after several days.

He stated both of his ankles ache and hurt and was wondering if that was related to his present injury.

CURRENT MEDICATIONS: 1) Pamelor, Effexor and Zoloft prescribed by Dr. Riaz; 2) Flexeril and Oxycontin prescribed by Dr. Snyder.

SOCIAL HISTORY: This patient is married and his wife is employed. He has two children from his previous marriage and one from this marriage. His children ages are 2, 4 and 7 years old. The 7 year old child is with his mother and the 2 and 4 year old children is with him and his wife. He does not smoke cigarettes or drink alcohol. Two times he has been denied Disability Social Security.

WORK HISTORY: He has a high school education. He worked at a hardware store and then did some logging jobs. He also set mobile homes. He drove a truck for a while. At the time of injury he was driving for D & M Corporation.

PAST HISTORY: **A) OTHER WORK RELATED INJURIES OR ILLNESSES** - History of injury to lower dorsal spine with possible fracture of T11 or T12 area versus wedging. He missed work from 1994 to 1997 on account of that injury. He was treated under the care of Dr. Snyder. He received 10% impairment from that injury.

B) NON WORK RELATED INJURIES OR ILLNESSES - 1) Auto accident in 1986-1987 with cerebral concussion and fracture collar bone; 2) No medical problems; 3) No surgical procedures.

PHYSICAL EXAMINATION: During his physical examination my office personnel, Candie was present in the examining room.

This patient is a 29 year-old-white male who was 65 inches tall and weighed 290 pounds. He was over-weight for his height. Today he was walking with a cane.

His ROM at neck is recorded on ROM Form. While checking his ROM he had some voluntary guarding. During history he was able to nod his head and move it freely. There was tenderness at cervicodorsal and left scapular areas. There was no true muscle spasm. Compression and distraction test caused some discomfort in his neck though Spurling sign was negative.

MEASUREMENTS

	RIGHT UPPER EXTREMITY	LEFT UPPER EXTREMITY	COMMENTS
Circumference of upper arm (10 cm above olecranon)	38.1 cm	37.2 cm	pt rt handed
Circumference of forearm (10 cm below olecranon)	34.0 cm	33.4 cm	

NEUROLOGICAL EXAMINATION

Reflexes - BJ, TJ & BRJ	1+	1+	
Muscle strength	5/5	5/5	all groups upper extremity muscle
Grip strength (Jamar apparatus @ Third notch)	0,20,5	20,10,0	poor effort noted

PHYSICAL EXAMINATION: Continued

NEUROLOGICAL EXAMINATION

	RIGHT UPPER EXTREMITY	LEFT UPPER EXTREMITY	COMMENTS
Pulse	2+	2+	
Cranial nerves	Intact	Intact	

His sensory examination revealed somewhat diminished sensation in left fourth and fifth fingers.

Examination of his shoulder areas revealed no gross atrophy of shoulder muscles. He had tenderness over the anterior and superior aspect of left shoulder and slightly over left AC joint.

RANGE OF MOTION

SHOULDERS	RIGHT	LEFT
Forward flexion/extension	170^{o}-0^{o}-60^{o}	100^{o}-0^{o}-50^{o}
Abduction/Adduction	170^{o}-0^{o}-40^{o}	90^{o}-0^{o}-35^{o}
External/internal rotation		
Arm at 90^{o} abduction	90^{o}-0^{o}-90^{o}	90^{o}-0^{o}-75^{o}

He had mild pain in left shoulder at extreme ROM. Impingement test was negative today. Apprehension test was negative.

His ROM at elbow, wrist and forearm is recorded on ROM Form and was identical and normal bilaterally.

Today he had no signs of thoracic outlet or carpal tunnel syndrome.

Examination of his rib cage area revealed chest sounds to be normal. He could breathe in and out without any problems. There was mild soreness in the anterior axillary line at the middle part of left rib cage. There was no history of shortness of breath. His gait was

PHYSICAL EXAMINATION: Continued
normal though he walked with cane. He could squat 20%. He could stand on toes and heels though there was some difficulty encountered. His ROM at lumbar spine is recorded on ROM Form and was not valid. His neurological examination revealed give away type of weakness and non-dermatomal decreased sensation in both legs.

Examination of his knees revealed ROM to be 0^{o}-0^{o}-130^{o}. There was no effusion in both knees. Collateral and cruciate ligaments were intact. McMurray, Lachman and pivot shift test were negative.

His ROM at ankle was dorsi/plantar flexion 15^{o}-0^{o}-40^{o}. Inversion/eversion was 35^{o}-0^{o}-10^{o} bilaterally. His ankle joints were stable. There was no swelling.

RADIOLOGICAL FINDINGS:
1) His x-rays of cervical spine, dorsal spine, lumbar spine, left hip, left ankle and pelvis were reported normal at the time of his injury. His MRI of left shoulder, done on 03/21/00 and later on 01/30/01, were reported normal.

2) His MRIs of cervical and lumbar spine, done on 09/12/00, were reported normal.

3) His x-rays of rib cage done on 08/30/00 was normal.

4) His x-rays of AC joint with and without weights done on 08/30/00 were reported normal.

DISCUSSION/CONCLUSION/RECOMMENDATIONS:
1) This patient has history of multiple injuries he sustained in a fall. He has been treated conservatively with medication and physical therapy. He is going through Pain Clinic injection which has not helped him much. His nerve conduction studies of upper extremities have been reported negative. All of his test including MRIs of neck, lower back and shoulder were reported normal.

Today on examination he had some limitation of ROM with voluntary guarding. His ROM at lumbar spine was not valid. He had some limitation of ROM at left shoulder. His neurological examination of upper and lower extremities were normal except for non-dermatomal decreased sensations in both legs and slightly diminished sensation in left little finger.

DISCUSSION/CONCLUSION/RECOMMENDATIONS: Continued

DIAGNOSES: A) Cervicodorsal and left scapular strain with cervical root irritation
B) Lumbosacral strain
C) Sprain left shoulder and AC joint
D) Blunt trauma left rib cage
E) Sprain left knee
F) Cerebral concussion

2) He has reached maximum degree of medical improvement. He is not found to be totally disabled.

3) He may continue periodic follow up for symptomatic treatment with his attending physician.

4) If it is agreed upon and scheduled by his attending physician he could go through a Functional Capacity Evaluation. Vocational follow up is recommended. His prognosis seems to be poor as he has already applied for Disability Social Security.

5) Using AMA Guidelines, Fourth Edition, 1993, his impairment rating from neck and lower back is calculated on Spine Impairment Summary Form. His impairment rating from shoulder is calculated on Upper Extremity Form. For detailed calculations, reference figures and tables please refer to those forms.

I have used ROM Method to calculate his final impairment rating and it is as follows:

AREA INVOLVED	% WHOLEMAN IMPAIRMENT
a. Chronic cervicodorsal and left scapular strain	12%
b. Lumbosacral strain	5%
c. Sprain left shoulder and AC joint	5%
d. Injury left rib cage	0%
e. Sprain left knee	0%
(Using Combined Value Charts) Total	20%

DISCUSSION/CONCLUSION/RECOMMENDATIONS: Continued
In summary, **this patient has 20% wholeman impairment from multiple injuries he sustained on 03/10/2000.** This impairment is non-progressive.

This impairment is in addition to the impairment he received from his claim #95-6803 while involved mostly his lower dorsal spine.

Thank you for sending this patient for evaluation. If you have any questions, please feel free to contact my office at any time.

Sincerely,

Saghir R. Mir, MD

SRM/mm
Enclosure

PLEASE NOTE: The opinions rendered in this case are the opinions of this evaluator. Recommendations regarding work and impairment ratings are given totally independently of the requesting agents. This evaluation has been conducted on the basis of the medical examination and documentation as provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service, report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation This opinion is based on a clinical assessment, examination and documentation. Any recommendation on impairment is based on AMA Guidelines, Fourth Edition. This opinion does not constitute, per se, a recommendation for specific claims or administrative functions to be made or enforced. Medicine is both an art and a science; and although a patient may appear to be fit to return to duty, there is no guarantee that the patient will not be re-injured or suffer additional injury once he/she returns. If further information is required, please contact me.

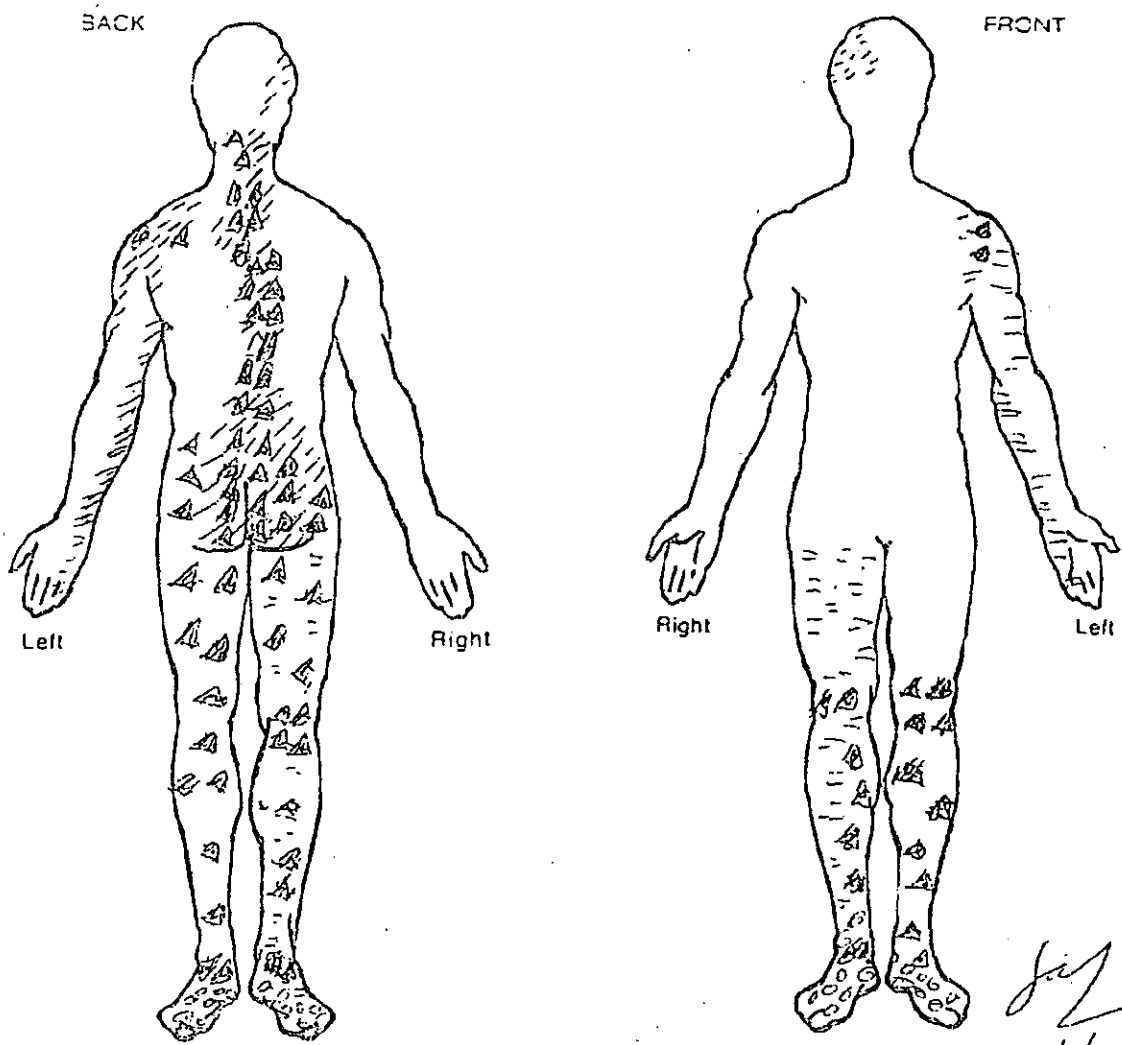
USE BLACK INK

INSTRUCTIONS

Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition. Draw in your face.

KEY CHRISTOPHER LESTER SS#[redacted]-3340 DOI -03-10-00 CLAIM #-2000046841 DOB [redacted]-71

/// Stabbing	X X X Burning	000 Pins and Needles	ΔΔΔ Aching, Throbbing	= = = Numbness	o o o Other



6/25/01

Signature [signature] Date 06-25-01

2000-46841
3/10/2000

Figure 79. Lumbar Range of Motion (ROM).*

CHRISTOPHER W. LESTER, SR. DOB: 12/23/71 SS#: 233-15-3340 DOI: 03/10/00 CLAIM#: 200004684

Name Christopher Lester Soc. Sec. No. [redacted]3340 Date 6/25/01

Movement	Description	Range					
Lumbar Flexion	T12 ROM	11	10	10			
	Sacral ROM	8	7	7			
	True lumbar flexion angle	7	2	3			
	± 10% or 5°?	Yes ✓	No				
	Maximum true lumbar flexion angle	7					
	% Impairment						
Lumbar Extension	T12 ROM	0	0	0			
	Sacral ROM	0	0	0			
	True lumbar extension angle	0	0	0			
	± 10% or 5°?	Yes ✓	No				
	Maximum true lumbar extension angle	0					(Add sacral flexion and extension ROM and compare to tightest straight-leg-raising angle)
	% Impairment						
Straight Leg Raising (SLR), Right	Right SLR	30	30	30			
	± 10% or 5°?	Yes ✓	No				(If tightest SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid)
	Maximum SLR right	30					
Straight Leg Raising, Left	Left SLR	30	30	30			
	± 10% or 5°?	Yes ✓	No				(If tightest SLR ROM exceeds sum of sacral flexion and extension by more than 15%, lumbar ROM test is invalid)
	Maximum SLR Left	30					
Lumbar Right Lateral Flexion	T12 ROM	15	15	16			
	Sacral ROM	2	2	2			
	Lumbar right lateral flexion angle	13	13	15			
	± 10% or 5°?	Yes ✓	No				
	Maximum lumbar right lateral flexion angle						
	% Impairment						
Lumbar Left Lateral Flexion	T12 ROM	17	16	16			
	Sacral ROM	2	2				
	Lumbar left lateral flexion angle	15	14	14			
	± 10% or 5°?	Yes ✓	No				
	Maximum lumbar left lateral flexion angle						
	% Impairment						
Lumbar Ankylosis in Lateral Flexion	Position						
	% Impairment						(Excludes any impairment for abnormal flexion or extension motion)

Total lumber range of motion and ankylosis* impairment _____ %

ROM not valid

*If ankylosis is present, combine the ankylosis impairment with the range of motion impairment (Combined Values Chart, p. 322). If ankyloses in several locations are present, combine the ankylosis impairments (Combined Values Chart) first, then combine the result with the range of motion impairment.

Did not meet SLR criteria

500688.086.0013

2000046841
3/10/2000

Figure 77. Cervical Range of Motion (ROM)*

CHRISTOPHER W. LESTER, SR. DOB: 12/23/71 SS#: 233-15-3340 DOI: 03/10/00 CLAIM#: 2000046841

Name Christopher Lester Soc. Sec. No. [redacted]-3340 Date 6/26/01

Movement	Description	Range					
Cervical Flexion	Occipital ROM	37	36	36			
	T1 ROM	2	2	2			
	Cervical flexion angle	31	34	34			
	±10% or 5°?	Yes	No				
	Maximum cervical flexion angle	35					
	% Impairment	1%					
Cervical Extension	Occipital ROM	38	39	38			
	T1 ROM	2	2	2			
	Cervical extension angle	36	37	36			
	±10% or 5°?	Yes	No				
	Maximum cervical extension angle	37					
	% Impairment	2%					
Cervical Ankylosis in Flexion/Extension	Position		(Excludes any impairment for abnormal flexion or extension motion)				
	% Impairment						
Cervical Right Lateral Flexion	Occipital ROM	22	22	22			
	T1 ROM	2	1	2			
	Cervical right lat flexion angle	20	21	20			
	±10% or 5°?	Yes	No				
	Maximum cervical right lat flexion angle	21					
	% Impairment	1%					
Cervical Left Lateral Flexion	Occipital ROM	21	21	22			
	T1 ROM	2	2	2			
	Cervical left lat flexion angle	19	19	20			
	±10% or 5°?	Yes	No				
	Maximum cervical left lat flexion angle	20					
	% Impairment	1%					
Cervical Ankylosis in Lateral Flexion and Extension	Position		(Excludes any impairment for abnormal lateral flexion or extension motion)				
	% Impairment						
Cervical Right Rotation	Cervical right rotation angle	55	54	55			
	±10% or 5°?	Yes	No				
	Maximum cervical right rotation angle	55					
	% Impairment	1%					
Cervical Left Rotation	Cervical left rotation angle	53	53	55			
	±10% or 5°?	Yes	No				
	Maximum cervical left rotation angle	55					
	% Impairment	1%					
Cervical Ankylosis in Rotation	Position		(Excludes any impairment for abnormal rotation)				
	% Impairment						

Total cervical range of motion and ankylosis* impairment 7 %

*If ankylosis is present, combine the ankylosis impairment with the range of motion impairment (Combined Values Chart, p. 322). If ankyloses in several planes are present, combine the estimates (Combined Values Chart), then combine the result with the range of motion impairment.

500688.086.0014

CHRISTOPHER W. LESTER, SR. DOB: 12/23/71
SS#: 233-15-3340 DOI: 03/10/00
CLAIM#: 2000046841

2000046841
3/10/2000

The Musculoskeletal System 3/17

Figure 1. Upper Extremity Impairment Evaluation Record—Part 2 (Wrist, elbow, and shoulder) Side ☐ R ☑ L

Name Christopher Lester Age ____ Sex ☐ M ☐ F Dominant hand ☑ R ☐ L Date 6/25/01

Occupation ____ Diagnosis Injury (L) shoulder + AC joint

	Abnormal motion					Other disorders	Regional impairment %	Amputation
	Record motion, ankylosis and impairment %					List type & impairment %	• Combine [1] + [2]	Mark level & impairment %
Wrist		Flexion	Extension	Ankylosis	IMP%			
	Angle°	60	60					
	IMP%	0	0		0			
		RD	UD	Ankylosis	IMP%			
	Angle°	10	35					
	IMP%	0	0		0			
	Add IMP% F/E + RD/UD =		0		[1]	IMP% = 0 [2]	0	
Elbow		Flexion	Extension	Ankylosis	IMP%			
	Angle°	140	0					
	IMP%	0	0		0			
		PRO	SUP	Ankylosis	IMP%			
	Angle°	80	80					
	IMP%	0	0		0			
	Add IMP% F/E + PRO/SUP =		0		[1]	IMP% = 0 [2]	0	
Shoulder		Flexion	Extension	Ankylosis	IMP%			
	Angle°	102	50					
	IMP%	5	0		5			
		ADD	ABD	Ankylosis	IMP%			
	Angle°	35	90					
	IMP%	0	4		4			
		INT ROT	EXT ROT	Ankylosis	IMP%			
	Angle°	75	90					
	IMP%	0	0		0			
	Add IMP% F/E + ADD/ABD + IR/ER =		9		[1]	IMP% = 0 [2]	9	IMP %

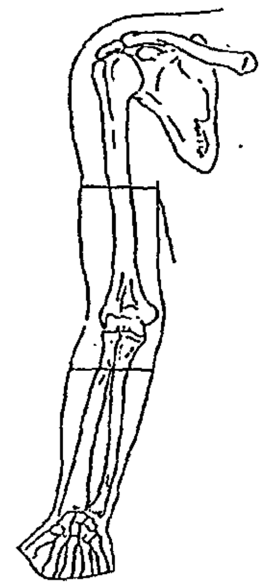


Fig 26,27

32,35

33,41,44

I. Amputation impairment (other than digits)	0 •
II. Regional impairment of upper extremity • (Combine hand 0 % + wrist 0 % + elbow 0 % + shoulder 9 %)	9 •
III. Peripheral nerve system impairment	0 •
IV. Peripheral vascular system impairment	0 •
V. Other disorders (not included in regional impairment)	0 •

Total upper extremity impairment (• Combine I + II + III + IV + V)	9 •
Impairment of the whole person (Use Table 3 p. 20)	9 = 5% Whole person

If both limbs are involved, calculate the whole-person impairment for each on a separate chart and combine the percents (Combined Values Chart).

[signature]

500688.086.0015

2000046841
3/10/2000

Figure 80. Spine Impairment Summary.

CHRISTOPHER W. LESTER, SR. DOB: 12/23/71 SS#: 233-15-3340 DOI: 03/10/00 CLAIM#: 2000046841

Name: Christopher Lester Soc. Sec. No.: [redacted]3340 Date: 6/25/01

Impairment			Cervical or Cervicothoracic	Thoracic or Thoracolumbar	Lumbar or Lumbosacral
1. Injury Model impairment	DRE Table 73, 74		DRE-5%		DRE-5%
2. Range of Motion Model impairment	No-4	No-4			
a. Based on diagnosis (Table 64, pp. 85-86)	75-II B	75-II B	4%		5%
b. Based on range of motion	76, 77, 78	81, 82	7%		0% (both not valid)
c. Neurologic system					
1. Loss of sensation					
2. Loss of strength	D, S	83	1%		0%
3. Regional impairment totals Combine impairments in each column using the Combined Values Chart (p. 322).			12%		5%
4. Total spine impairment (Combine regional impairments)					

500688.086.0016

Rev. 1-98

WORKERS' COMPENSATION DIVISION
LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* — *Page 1*

Patient Name: CHRISTOPHER LESTER
SSN: [redacted]-3340 **HT.** 6'
Date of Injury: 03/10/00 **WT.** 270#
Date of Birth: [redacted]71 **Pulse** ____
Claim Number 2000046841 **BP** ____
Date of Exam: 06/25/01 **Resp.** ____

Physician: SAGHIR R. MIR, MD
Address: PO BOX 839
MONTGOMERY, WV 25136
Phone: (304)442-5176
FEIN: 55- 0564990

PLEASE CHECK ONE OR MORE:
☐ CLAIM REOPENING ☒ IMPAIRMENT RATING ☐ 120-DAY EXAMINATION
☐ CONSULTATION ☒ INDEPENDENT EXAMINATION ☐ COMPREHENSIVE EXAMINATION

1. INSPECTION (standing)

	YES	NO	
1.1 Patient stands unassisted	☒	☐	
1.2 Scoliosis	☐	☒	
1.3 Antalgic lean (Asymmetry)	☐	☒	
1.4 Lumbar hypolordosis	☐	☒	
1.5 Lumbar hyperlordosis	☐	☒	

Other observations ____

2. PALPATION (standing, seated, or prone)

	YES	NO					
2.1 Vertebral tenderness/restriction	☒	☐	☐L1	☐L2	☐L3	☐L4	☐L5
2.2 Coccyx tenderness (external palpation)	☐	☒					
2.3 Sacral base & pelvis level (Standing)	☒	☐					

	LEFT		RIGHT	
	YES	NO	YES	NO
2.4 Paraspinal muscle tenderness	☒	☐	☐	☐
2.5 Paraspinal muscle spasm	☐	☒	☐	☐
2.6 Sacroiliac joint tenderness	☐	☒	☐	☐

3. GAIT

3.1 Limp ☐ Yes ☒ No ☐ Left ☐ Right Explain: ____
3.2 Assistive devices (cane, brace, prosthesis) cane
3.3 Other observations ____

4. SQUAT

20 %

4.1 Squats fully and rises without difficulty ☒ Yes ☐ No
Comments ____

5. RANGE OF MOTION (standing) *

		WNL	PAIN	RESTRICTION
5.1 Forward bending (Flexion)	____°	☐	☐	☐
5.2 Backward bending (Extension)	____°	☐	☐	☐
5.3 Left side bending	____°	☐	☐	☐
5.4 Right side bending	____°	☐	☐	☐

5.5 Comments ____
5.6 Inclinometer ☒ Yes ☐ No (Inclinometer required for impairment examinations)

* NOTE: Subtract sacral motions from T12 motions (pp. 3/126-129 AMA Guides, 4th ed.)

RANGE OF MOTION CERTIFICATION

Thoracolumbar motion testing is valid if the following four criteria are achieved. Please certify the status of the examinee on each of these four criteria:

- The back injury is now stable. ☒ Yes ☐ No
- The motions were not curtailed due to a report of pain, fear of injury, or neuromuscular inhibition. ☐ Yes ☐ No
- Three consecutive measurements of each motion were within 5° (within 10° if the three averaged 50° or more.) ☒ Yes ☐ No
- Examinee passed validity test. ☐ Yes ☐ No

Physician's Signature

Source: AMA Guides to the Evaluation of Permanent Impairment, pp. 112 & 127.

Page 2

Patient's Name CHRISTOPHER LESTER Date of Exam 06-25-01 Claim Number 2000046841

6. MOTOR STRENGTH (standing, walking, seated, or supine) GRADE (OUT OF 5)

	NORMAL	ABNORMAL	LEFT	RIGHT
6.1 Hip flexion	☐	☐		
6.2 Hip Extension	☐	☐		
6.3 Hip Abduction	☐	☐		
6.4 Knee extension	☐	☐	5	5
6.5 Knee flexion	☐	☐	5	5
6.6 Ankle dorsiflexion	☐	☐		
6.7 Ankle Planter flexion	☐	☐	4/5	4/5
6.8 Great toe extension	☑	☐		
6.9 Heel toe walk	☑	☐		
6.0 Toe walk	☑	☐		

both upright.. — gave hesitancy & gives way;

7. SENSORY (pin prick) (seated or supine)

	LEFT Normal	LEFT Diminished	LEFT Absent	RIGHT Normal	RIGHT Diminished	RIGHT Absent
7.1 L3 sensory	☐	☐	☐	☐	☐	☐
7.2 L4 sensory	☐	☐	☐	☐	☐	☐
7.3 L5 sensory	☐	☐	☐	☐	☐	☐
7.4 S1 sensory	☐	☐	☐	☐	☐	☐

7.5 Comments stocking type decreased sensation both legs

8. REFLEXES (seated) (+2 normal)

Patellar	8.1 Left	☐ 0	☐ +1	☑ +2	☐ +3	☐ clonus
	8.2 Right	☐ 0	☐ +1	☑ +2	☐ +3	☐ clonus
Achilles	8.3 Left	☐ 0	☐ +1	☑ +2	☐ +3	☐ clonus
	8.4 Right	☐ 0	☐ +1	☑ +2	☐ +3	☐ clonus

Other

9. STRAIGHT LEG RAISING (sitting) (0-90° scale)
(Measure knee extension)

8.1 Left 80° Pain: ☑ Yes ☐ No Location of Pain: ☑ Back ☐ Same Leg ☐ Contralateral back/leg
8.2 Right 80° Pain: ☑ Yes ☐ No Location of Pain: ☑ Back ☐ Same Leg ☐ Contralateral back/leg

10. HIP AND SACROILIAC TESTS

10.1 Hip test pain ☐ Yes ☑ No ☐ Left ☐ Right

10.2 Sacroiliac test pain ☑ Yes ☐ No ☑ Left ☑ Right

11. STRAIGHT LEG RAISING (supine) (0-90° scale)

11.1 Left 30° Pain: ☑ Yes ☐ No Location of Pain: ☑ Back ☐ Same Leg ☐ Contralateral back/leg
11.2 Right 30° Pain: ☑ Yes ☐ No Location of Pain: ☑ Back ☐ Same Leg ☐ Contralateral back/leg

Lasegue Negative

12. PULSES

			Left	Right
12.1 Dorsalis Pedis	2	Present?	Yes ☑ No ☐	Yes ☑ No ☐
12.2 Posterior tibial	2	Present?	Yes ☑ No ☐	Yes ☑ No ☐

12.3 Other observations (Clubbing, Cyanosis)

13. MUSCLE MEASUREMENT

13.1 Left Thigh 62.0 Right Thigh 62.5 20 cm above tibial tubercle
13.2 Left Calf 47 Right Calf 47.5 10 cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical ☐ Yes ☐ No ☐ Not Tested
14.2 Shorter ☐ Left ☐ Right ☐ Supine ☐ Standing
Difference of ____ cm Right 94 cm Left 94 cm

☐ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ☐ Standing: measure from greater trochanter to floor

15. OTHER TESTS AND FINDINGS

16. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION — SCORE

SENSORY EXAMINATION: RESPONSE TO PINPRICK (check)

16.1 No deficit or deficit well localized to dermatome(s) 0 ☐
Deficit related to dermatome(s) but some inconsistency 1 ☐
Nondermatomal or very inconsistent deficit 2 ☐
Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test) 3 ☐ — 2

16.2 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐ — 1

MOTOR EXAMINATIONS (check)

16.3 No deficit or deficit well localized to myotome(s) 0 ☐
Deficit related to myotome(s) but some inconsistency 1 ☐
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable 2 ☐
Blatantly impossible, significant weakness which disappears when distracted 3 ☐ — 2

16.4 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐ — 1

TENDERNESS (check)

16.5 No tenderness or tenderness localized to anatomically sensible structure 0 ☐
Tenderness not well localized, some inconsistency 1 ☐
Diffuse or inconsistent tenderness, multiple structures (skin, muscle, bone, etc.) 2 ☐
Impossible, significant tenderness of multiple structures (skin, muscle, bone, etc.) which disappears when distracted 3 ☐ — 2

16.6 AMOUNT OF BODY INVOLVED (check)
<15% 0 ☐ 15-35% 1 ☐ 36-60% 2 ☐ >60% 3 ☐ — 0

DIFFERENTIAL STRAIGHT LEG RAISING (SLR)

16.7 The difference between SLR tests performed in the supine and sitting positions (the patient is distracted in the sitting position by examining the bottom of his/her feet). Example: supine SLR positive at 10°, seated SLR positive at 50°, difference = 40°. (check)
Difference <20° 0 ☐ 20-45° 1 ☐ >45° 2 ☐
No pain seated, but strongly positive SLR when supine at less than 45° 3 ☐ — 2

TOTAL SCORE 8

17. COMMENTS

Patient's Name CHRISTOPHER LESTER Date of Exam 06-25-01 Claim Number 2000046841

18. RADIOGRAPHIC EXAM ☐ Yes ☐ No Date _____ Type (Plain, CT, MRI, Myelogram) _____

Findings (Attach report if available): _____

Patient Position During X-ray: ☐ Recumbent ☐ Weight Bearing ☐ Unknown

19. CLINICAL DIAGNOSIS

(Please indicate appropriate ICD-9 code(s) and give written description. Generic diagnoses are printed for your convenience; you may substitute other diagnoses. If appropriate, multiple diagnoses can be designated.)

SOFT TISSUE
- ☐ Lumbar sprain/strain (847.2)
- ☑ Lumbosacral sprain/strain (846.0)
- ☐ Sacroiliac sprain/strain (846.1)

POSTERIOR JOINTS
- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation (839.20) or segmental dysfunction (739.3) (circle)

DISC
- ☐ Lumbar disc displacement without myelopathy (with or without radiculitis) (722.10)
- ☐ Lumbosacral radiculitis (724.4)

SACROILIAC
- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation (839.42) or segmental dysfunction (739.4) (circle)

☐ OTHER: _____

20. RECOMMENDATIONS, OPINION, REFERRALS, TX PLAN OR REDIRECTION: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

22. PHYSICIAN'S SIGNATURE _____ DATE 6/25/01

SAGHIR R. MIR, M.D., F.A.A.O.S.
ORTHOPAEDIC SURGERY
MONTGOMERY GENERAL HOSPITAL
MONTGOMERY, WEST VIRGINIA 25136

TELEPHONE (304) 442-5176
(304) 442-5151 EXT. 100

December 28, 2000

Workers' Compensation Fund
PO Box 431
Charleston, WV 25322

RE: LESTER, CHRISTOPHER W., SR.
DOB: [redacted]-71
SS#: [redacted]-3340
DOI: 03-10-00
CLAIM#: 2000046841
EMPLOYER: D & M TRUCKING CORPORATION INC.

Dear Sir/Madam:

This patient was evaluated by me on 12-22-00 at your request. His extensive records on films as well as CD were reviewed. Patient brought several reports from his physician's office and copies of those reports were made and those records were reviewed.

In addition to this Compensation sent me 13 films of records regarding his injury of 08-10-94 which were partly reviewed by me. History was obtained and physical examination was carried out.

During his examination my office personnel Crystal and his wife were present in the examining room.

REVIEW OF RECORDS AND HISTORY: Records indicate that this patient first time injured his lower back was on 08-10-94 with claim #95-6803. This injury happened when he was carrying some header and he slipped and fell. He was under the care of Dr. Chinundat and saw several physicians during his treatment from 1994 to 1997. He was seen at the pain clinic by Dr. Nelson. His x-rays of lumbosacral spine had revealed patient had some wedging at D11 vertebrae. He had special views and it was felt it was more of a wedging. He had an MRI on 08-03-96 which reported no disc herniation. Patient continued to have back pain with some right leg pain. He had IME's done by Dr. Hill and Dr. Bachwitt. Dr. Bachwitt evaluated him in 1997 and recommended 5% impairment. Patient stated he would receive 10% impairment at the recommendation of Dr. Hill. There were extensive vocational rehabilitation papers in his file. He was rehabilitated to be a driver.

His present injuries happened on 03-10-00 when he was checking oil in a truck and hood knocked him backwards and he fell four or five feet away. He landed on another truck and was knocked unconscious. He was seen at CAMC in the emergency room by Dr. Bailey. He had multiple x-rays which were reported normal.

REVIEW OF RECORDS AND HISTORY: Continued.
He had x-ray of cervical spine, dorsal spine and lumbar spine which were all negative. He had x-ray of left hip, pelvis, shoulder and ankle which were also normal. He had CT Scan of head and cervical spine which were all essentially within normal limits. He was discharged from the hospital. He was told to follow up at Corporate Health.

Patient continued follow up at Corporate Health under the direction of Dr. Marsha Bailey. Patient specified that he saw four or five physicians at the clinic. Anyhow his main physician was Dr. Bailey. She treated him conservatively with medication and physical therapy. He complained of some drainage from his right ear. There was some question of him seeing Dr. Apple but I believe it was more of a verbal consultation. He continued to have some pain in right ear with some drainage so he was referred for ENT consultation with Dr. Phillips.

On 03-15-00 Dr. Bailey noted that patient had seen Dr. Phillips and had audiogram done which revealed some hearing loss bilaterally which was not related to injury. Dr. Phillips did not feel he had any fractures and did not recommend any additional treatment for his ear. On 03-15-00 Dr. Bailey checked his ear and did not find any drainage. As patient was continuing to complain of symptoms in left shoulder so an MRI of left shoulder was scheduled. On 03-21-00 he had an MRI of left shoulder at CAMC which reported no evidence of rotator cuff tear. On 03-22-00 Dr. Bailey noted patient was still having pain in neck and left shoulder area with headaches. He was started on physical therapy. On 03-27-00 Dr. Bailey noted his MRI of shoulder to be normal. He had limited range of motion. He started physical therapy at Boone Memorial Hospital on 04-03-00.

During that time this patient requested to transfer under the care of Dr. Snyder on 04-06-00. Compensation allowed such transfer. Patient stated he had previously been treated by Dr. Snyder for his previous injury. On 04-07-00 Dr. Snyder noted patient had sustained multiple injuries. He was complaining of pain in his neck and left shoulder area. He was started on MOTRIN, FLEXERIL and VICODIN. Patient continued to see Dr. Snyder at couple of week intervals. On 04-26-00 he was still having more or less same symptoms. He was continued on physical therapy and medications.

During that time patient was allowed to return to work on light duty. On 04-18-00 he was released but there was no light duty work available through employer. At that time he was referred to Vass Rehab Services. On 05-05-00 he had initial vocational evaluation. Patient continued to have periodic follow up with rehab counselor. Over a period of time reviewed were periodic progress notes.

During May and June of 2000 patient continued to see Dr. Mark Snyder at two week intervals. He was having persistent symptoms at neck, left shoulder and lower back. Dr. Snyder mentioned about possibility of consultation by Dr. Loimil. On 06-19-00 his physical therapy was stopped as it increased his symptoms.

REVIEW OF RECORDS AND HISTORY: Continued.
On 08-02-00 this patient was evaluated by me for West Virginia Compensation. At that time I recommended for this patient to have MRI of neck, lower back and x-ray on his left AC joint. I recommended for this patient to have an Orthopaedic consultation with Dr. Loimil, a neurosurgical consultation and pain clinic consultation. Somehow during the last four months he has not been going to pain clinic and has been treated with narcotics by his physician along with some nerve medications.

At my recommendation this patient did have MRI of cervical spine and lower back which were reported normal. On 10-02-00 patient had nerve conduction studies and EMG which were reported normal by Dr. Pratt. He had no evidence of peripheral neuropathy or cervical radiculopathy. His MRI of neck and back were done on 09-12-00. He had x-ray of left AC joint on 08-30-00. His x-ray of left rib done on the same day were reported normal.

On 10-06-00 he saw Dr. Amores for neurosurgical consultation. Dr. Amores noted patient complaining of still neck pain going into left arm. His neurological examination was reported normal. His various x-rays and MRI of cervical and lumbar spine were reported normal. Dr. Amores felt patient had musculoskeletal strain of cervical and lumbar spine without neurological deficit. Conservative treatment was recommended.

On 08-17-00 patient was seen by Dr. Loimil who noted him having still pain in left shoulder with limited range of motion. It was a detailed five page report from Dr. Loimil. I did not see Dr. Loimil mentioning about his previous MRI of left shoulder which was done on 03-21-00. Anyway Dr. Loimil recommended for this patient to have MRI of left shoulder. Dr. Loimil indicated that he will accept him as a patient to treat his left shoulder.

Reviewed were physical therapy reports from Boone Memorial Hospital dated 10-05-00 in his file. They noted patient started back on physical therapy on 08-31-00 and finished it on 09-06-00. They also noted he missed some of his appointments. Patient stated at present he is not taking any more treatments and is finished with his physical therapy.

Patient continued to see Dr. Snyder periodically. Reviewed were some of the office notes which were brought in by the patient. He saw him on 08-07-00, 09-26-00, 10-11-00 and 11-19-00. More or less he was continued on his medication. On 11-27-00 Dr. Snyder noted he was still having pain in neck, lower back and shoulder area. He was waiting to see Dr. Loimil. Also Dr. Snyder indicated he was waiting to go to pain clinic and see Dr. Loimil. They were planning to make him an appointment with Dr. Settle for psychiatric problem.

Patient stated after Thanksgiving he was hospitalized for five days as his legs gave out and he fell striking his dorsal spine against the steps. On 12-12-00 his physician noted that he has been taking OXYCONTIN which is helping him. This was supplemented with HYDROCODONE.

REVIEW OF RECORDS AND HISTORY: Continued.
He was still having generalized pain. He had contusion of dorsal spine with questionable fracture which they could not tell whether it was new or old.

At present patient uses heating pad or ice and does some massage at home. He indicated that his MRI of shoulder is going to be approved and after that he is going to see Dr. Loimil. He was going to see Dr. Settle also and was planning to be seen at the pain clinic.

Patient indicated he has applied for Disability Social Security which was denied and he has protested that decision. Patient is going to be 29 tomorrow and he has worked a total of four or five years and he indicated that he had enough weeks to be considered for Social Security. Patient stated he has checked into that already.

PRESENT COMPLAINTS AND FUNCTIONAL LIMITATIONS: Patient continues to have pain in neck and both scapular areas all the time. Intermittently pain goes into left arm. He had numbness and tingling on the medial side of forearm and especially in left little and ring finger. He has weakness around his left shoulder and upper extremity.

He still has pain in left shoulder. It aches and hurts all the time. He has decrease in mobility. His pain is mostly in front of the shoulder. He can not lie on the left side. At night time symptoms wake him up.

His lower back aches and hurts all of the time. He has pain in right hip and SI joint area. Pain goes into back part of right thigh. His pain was in the same areas as it was following his injury of 1994 except it is worse. Occasionally he has some pain over the tip of tail bone area. He has some numbness and tingling in both feet.

Prolong standing, sitting, walking or riding in a car increases his symptoms. Lying down does not help him much. He has no urinary or bowel symptoms.

CURRENT MEDICATION: 1) OXYCONTIN 2) MOTRIN 3) FLEXERIL 4) ATIVAN 5) PAXIL 6) VICODIN 7) ELAVIL

SOCIAL/WORK/PAST HISTORY: Please refer to my dictation of 08-02-00. Since then patient has applied for Disability Social Security.

PHYSICAL EXAMINATION: Patient is 29 year-old-white male who was 65 inches tall and weighed 276 pounds. His general physical condition was satisfactory.

His range of motion at cervical spine is recorded on West Virginia Compensation Range of Motion Form. He had marked voluntary guarding during the range of motion and actively resisted his range of motion. There was no true muscle spasm. There was some tenderness at cervicodorsal and both scapular area more so on the left. Compression/distraction test caused some discomfort in neck, though Spurling sign was negative.

PHYSICAL EXAMINATION: Continued.

MEASUREMENTS

	RIGHT UPPER EXTREMITY	LEFT UPPER EXTREMITY	COMMENTS
Circumference of upper arm (10 cm above olecranon)	37.5 cm	36.1 cm	pt rt handed
Circumference of forearm (7 cm below olecranon)	33.7 cm	31.2 cm	

NEUROLOGICAL EXAMINATION

Reflexes - BJ, TJ & BRJ	1 to 2+	1 to 2+	
Muscle strength	5/5	5/5	all groups upper extremity muscles
Grip strength	40,40,36	30,28,28	
Pulse	2+	2+	
Cranial nerves	Intact	Intact	

Sensory examination revealed patient had somewhat diminished sensation along the medial side of forearm and left fourth and fifth finger. Phalen and Tinel signs were negative. There was no signs of thoracic outlet syndrome.

His examination of shoulder area revealed no visible atrophy. He had tenderness mostly over the anterior part of left shoulder. There was very slight tenderness over left AC joint.

RANGE OF MOTION

SHOULDERS	RIGHT	LEFT
Forward flexion/extension	170^0-0^0-60^0	90^0-0^0-45^0
Abduction/Adduction	170^0-0^0-40^0	90^0-0^0-30^0
External/internal rotation		
Arm at 90^0 abduction	90^0-0^0-90^0	70^0-0^0-80^0

PHYSICAL EXAMINATION: Continued.
Patient had some discomfort at extreme of range of motion. Apprehension test was negative. Today impingement tests were negative.

Patient has no signs of thoracic outlet or carpal tunnel syndrome. His range of motion at elbows was 0^0-0^0-140^0 with supination/pronation 80^0-0^0-80^0 bilaterally. Dorsi/volar flexion at wrist was 60^0-0^0-60^0 with ulnar/radial deviation 35^0-0^0-15^0 bilaterally.

His examination of rib cage area revealed he had mild tenderness on the left rib cage area.

For detailed examination of lower back is recorded on West Virginia Compensation Back Form. His range of motion at lumbar spine was not found to be valid. His straight leg raising while seated was noted to be up to 90^0.

Today I could not examine this patient lying down as patient stated he does not tolerate it well.

RADIOLOGICAL FINDINGS:
1) Patient's x-ray of cervical spine, dorsal spine, lumbar spine, pelvis, left hip, left ankle and chest were reported normal at the time of injury.

2) His CT Scan of cervical spine and CT Scan of head at the time of injury were reported normal.

3) His MRI of left shoulder done on 03-21-00 was reported normal.

4) Patient had MRI of cervical spine and lumbar spine on 09-12-00 which were reported normal.

5) His x-ray of rib cage done on 08-30-00 were reported normal.

6) Patient's x-ray of AC joint with and without weights on 08-30-00 were reported normal.

DISCUSSION/CONCLUSION/RECOMMENDATIONS:
1) This patient first time injured his lower back on 08-10-94 at that time there was question of wedging versus compression at T11 vertebrae. He was treated conservatively. He was off from work from 1994 until 1997. Patient stated he has received 10% wholeman impairment from Compensation at the recommendation of Dr. Hill.

2) Patient sustained multiple injuries on 03-10-00. He has been treated conservatively and continues to stay symptomatic. On physical examination patient's range of motion at cervical spine and lumbar spine was limited on account of voluntary guarding. He has some limitation of range of motion at shoulder with tenderness over bicipital groove area.

DISCUSSION/CONCLUSION/RECOMMENDATIONS: Continued.
His neurological examination of lower extremity revealed stalking type of decreased sensation with give away type of weakness in lower extremities. His reflexes in upper and lower extremity were normal. He had slightly diminished sensation along the medial side of forearm. His Nerve Conduction Studies and EMG Studies done on 10-02-00 revealed no cervical radiculopathy or peripheral neuropathy including carpal tunnel syndrome.

DIAGNOSES:
1) Cervicodorsal and left scapular strain with cervical root irritation
2) Lumbosacral and sacroiliac strain
3) Sprain left shoulder with bicipital tendinitis
4) Cerebral concussion

3) He has not reached maximum degree of medical improvement. Patient continues to be temporarily disabled and an anticipated period of disability could be another four months.

4) As far as further treatment is concerned this patient should go ahead and have a repeat consultation with Dr. Loimil and repeat MRI of left shoulder. I will also recommend compensation to go ahead and let this patient have psychiatric consultation and pain clinic consultation. The sooner those consultations and treatments are allowed the lesser the period of his temporary disability will be.

5) As soon as he finishes his consultation he should be able to go through Functional Capacity Evaluation. As far as prognosis of this patient is concerned it is very poor. I doubt if this patient will return to work. He has already applied for Disability Social Security. Vocational follow up is recommended.

6) His impairment rating is deferred for another four months. Again please authorize this patient to see Dr. Loimil, Dr. Settle and go to pain clinic as soon as possible and authorize the necessary treatment recommended through those consultations.

Thank you for sending this patient for evaluation. If you have any questions, please feel free to contact my office at any time.

Sincerely,

Saghir R. Mir, MD

SRM/ajs
Enclosures

PLEASE NOTE: The opinions rendered in this case are the opinions of this evaluator. Recommendations regarding work and impairment ratings are given totally independently of the requesting agents. This evaluation has been conducted on the basis of the medical examination and documentation as provided with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service, report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination and documentation. Any recommendation on impairment is based on AMA Guidelines, Fourth Edition. This opinion does not constitute, per se, a recommendation for specific claims or administrative functions to be made or enforced. Medicine is both an art and a science; and although a patient may appear to be fit to return to duty, there is no guarantee that the patient will not be reinjured or suffer additional injury once he returns. If further information is required, please contact me.

USE BLACK INK

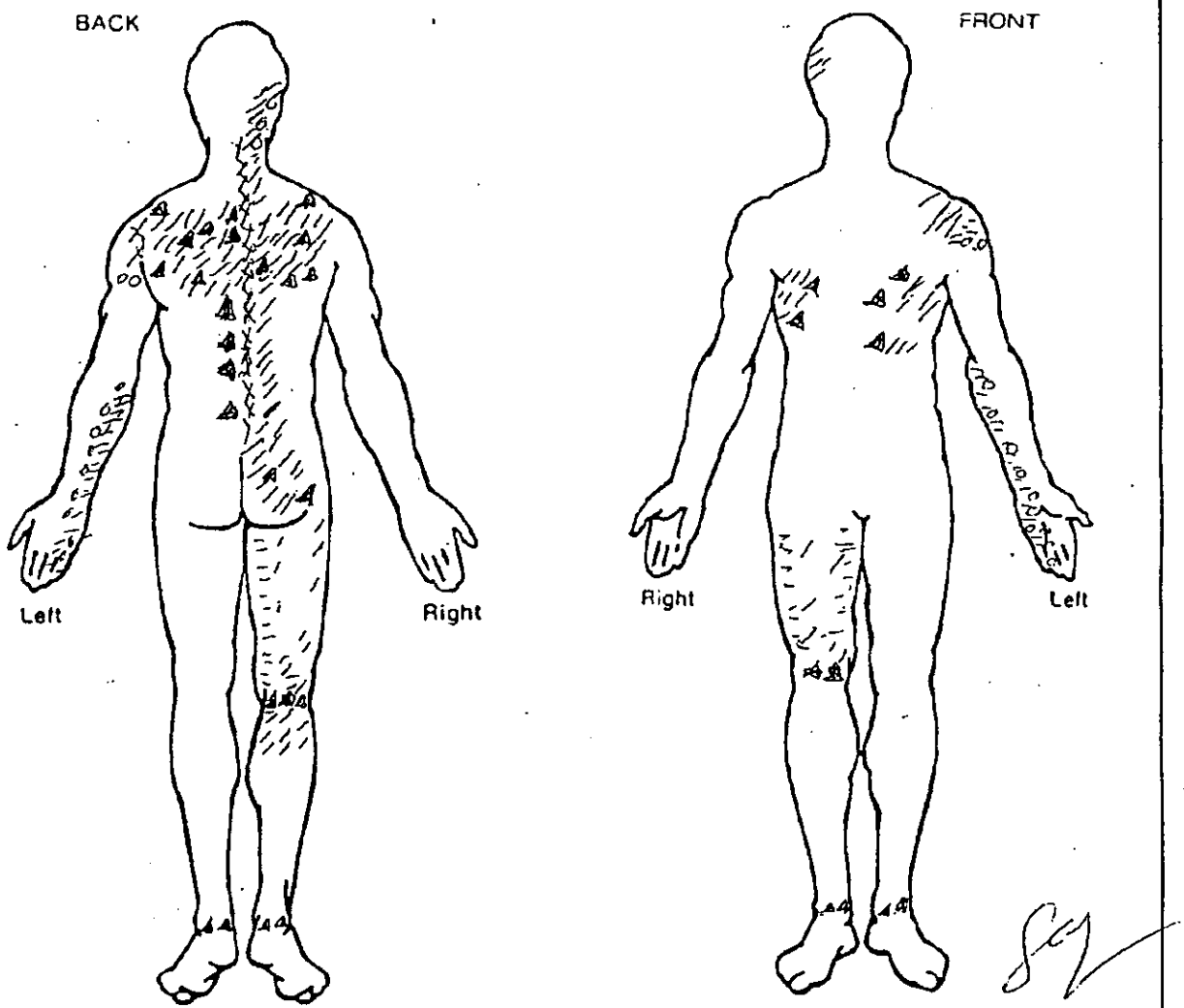
INSTRUCTIONS

Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition. Draw in your face.

KEY

/// Stabbing	X X X Burning	000 Pins and Needles	▲▲▲ Aching, Throbbing	= = = Numbness	• • • Other

CHRISTOPHER W. LESTER, SR. DOB: [redacted]71 SS #[redacted]3340 DOI: 03-10-00
CLAIM #2000046841



Signature Chris Lester Date 12-22-00

2000046841

CHRISTOPHER W. LESTER, SR. DOB: [redacted]71 SS #235-15-3340 DOF: 03-10-00

Figure 77. Cervical Range of Motion (ROM).*

CLAIM #2000046841

Name Christopher Lester Soc. Sec. No. [redacted]3340 Date 12/22/00

Movement	Description	Range					
Cervical Flexion	Occipital ROM	20	20	25			
	T1 ROM	2	2	3			
	Cervical flexion angle	18	18	22			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical flexion angle	22					
	% Impairment						
Cervical Extension	Occipital ROM	32	31	31			
	T1 ROM	2	2	2			
	Cervical extension angle	30	25	29			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical extension angle	30					
	% Impairment						
Cervical Ankylosis in Flexion/Extension	Position						
	% Impairment	(Excludes any impairment for abnormal flexion or extension motion)					
Cervical Right Lateral Flexion	Occipital ROM	18	18	17			
	T1 ROM	2	2	2			
	Cervical right lat flexion angle	16	16	15			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical right lat flexion angle	16					
	% Impairment						
Cervical Left Lateral Flexion	Occipital ROM	18	18	18			
	T1 ROM	2	2	2			
	Cervical left lat flexion angle	16	16	16			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical left lat flexion angle	16					
	% Impairment						
Cervical Ankylosis in Lateral Flexion and Extension	Position						
	% Impairment	(Excludes any impairment for abnormal lateral flexion or extension motion)					
Cervical Right Rotation	Cervical right rotation angle	45	51	53			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical right rotation angle	45					
	% Impairment						
Cervical Left Rotation	Cervical left rotation angle	40	40	40			
	≥ 10% or 5°?	Yes — No					
	Maximum cervical left rotation angle	40					
	% Impairment						
Cervical Ankylosis in Rotation	Position						
	% Impairment	(Excludes any impairment for abnormal rotation)					

Total cervical range of motion and ankylosis* impairment _____ % NOT RATED

*If ankylosis is present, combine the ankylosis impairment with the range of motion impairment (Combined Values Chart, p. 322). If ankylosis in several planes are present, combine the estimates (Combined Values Chart), then combine the result with the range of motion impairment.